No. 89-1044

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Petitioners,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals For the First Circuit

---

REPLY BRIEF OF PETITIONERS OCEAN STATE PHYSICIANS HEALTH PLAN, INC., ET AL.

Of Counsel
CLARK C. HAVIGHURST
Duke University Law School
Durham, N.C. 27706

THOMAS E. LYNCH
LYNCH AND GREENFIELD
203 South Main Street
Providence, R.I. 02903

WILLIAM G. KOPIT *
ROBERT W. MCCANN
EPSTEIN BECKER & GREEN, P.C.
1227 25th Street, N.W.
7th Floor
Washington, D.C. 20037
(202) 861-0900
Counsel for Petitioners

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

TABLE OF CONTENTS

TABLE OF AUTHORITIES

REPLY BRIEF OF PETITIONERS OCEAN STATE PHYSICIANS HEALTH PLAN, INC., ET AL.

SUMMARY

Petitioners have argued that their petition for a writ of certiorari should be granted in order that this Court can provide appropriate guidance regarding the evidence necessary to support a charge of non-price predation under Section 2 of the Sherman Act. More specifically, petitioners have argued that conduct labeled as "exclusionary" by a trier of fact in a non-price predation case cannot be deemed lawful per se merely because such conduct seems to contribute something to economic efficiency by reducing the defendants' costs. Pet. 10-13; *see also* AMCRA Am. Br. 5-7. Additional guidance is necessary both to protect emerging competition in the market for private health insurance and to guard against proliferation of erroneous principles of antitrust jurisprudence. Pet. 16-22; *see also* AMCRA Am. Br. 4; USHC Am. Br. 6-7; GHAA Am. Br. 5-6; Kaiser Am. Br. 5-7; AMA Am. Br. 7; ADA Am. Br. 3.[1]

In an attempt to minimize the significance of this case and petitioners' contentions, respondent relies on a series of specious arguments and erroneous factual assertions.[2] Respondent is wrong on many counts.

---

[1] The significant interest in this case expressed by commentators and scholars confirms its importance. *See* Busey, *Health Care Developments,* 58 Antitrust L.J. 457, 460 (1989); Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs,* 14 Am. J.L. & Med. 147 (1988); Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?,* L. & Contemp. Probs., Spring 1988, at 195; Stenger, *Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?,* 15 Am. J.L. & Med. 111 (1989).

[2] Respondent does not, however, contest petitioners' contentions that non-price predation involves considerations which are different from predatory pricing, and that this Court has never identified the appropriate evidentiary standard for predatory pricing cases. Pet. 12 n.10.

ARGUMENT

This Case Involves Significant Issues of Antitrust Jurisprudence

Respondent asserts that the court of appeals, after reviewing the trial record, merely determined that Blue Cross' conduct furthers competition on the merits, Br. Opp. 12, and that petitioners' challenge is barred because they "took no exception to the [district court's] Sherman Act Section 2 charge." *Id.* at 13. Reading these assertions in isolation, one would conclude the jury had found for respondent Blue Cross, not petitioners, and that having failed to object to the Court's instructions, petitioners cannot now attack the verdict. In this case, however, after being properly charged by the district court, the jury found that Blue Cross' conduct was unnecessarily restrictive of competition and "exclusionary."

There can be no doubt that the court of appeals created an unprecedented theory of per se legality rather than merely making a "fact-specific" determination, as respondent suggests. *Id.* at 9-10.[3] Both the trial court and the court of appeals ruled that, notwithstanding the sufficiency of the evidence supporting the jury's conclusions, the conduct at issue could not be deemed "exclusionary," as a matter of law, because it may have reduced respondent's costs to some extent.[4] In upholding respondent's

---

[3] The trial judge himself, in denying respondent's motion for a directed verdict, recognized that the evidence was sufficient to permit the jury to determine its significance on competition. As stated by the trial court, "it seems to me I am required to permit the jury to decide at this point whether or not the combination of weapons that Blue Cross-Blue Shield put together in its competitive package had an anticompetitive effect. . . ." Pet. App. 83a.

[4] Thus, the courts below deprived petitioners of the benefit of their proof simply because Blue Cross could point to some slight monetary savings which it derived from the operation of its "prudent buyer" policy. Indeed, it is possible that these savings, meager as they were, were more than offset by the losses which Blue Cross incurred through the initiation of its Healthmate product, which the court of appeals shielded from antitrust analysis through application of the

"prudent buyer" plan because it was conduct of a kind that normally "tends to further competition on the merits," the court of appeals created a precedent under which any other conduct of a monopolist that on its face had a similar tendency would also be shielded from further scrutiny under Section 2. If allowed to stand, this holding could have far-reaching affects.

This Court has never held that the mere existence of some efficiency or business justification—e.g., reduced costs—is sufficient to immunize any conduct, regardless of its actual monopolistic purpose and effect. If a plausible business purpose were an absolute defense, Section 2 could be easily evaded. Indeed, virtually all mergers and joint ventures would be permissible, which is obviously not the law. *See Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984).[5] Yet, according to the court of appeals, a monopolist's conduct will be immunized if a colorable "business justification" or "efficiency" can be proffered. Pet. App. 19a. Under this restrictive view

---

McCarran-Ferguson exemption. In this regard, it is undisputed that Blue Cross did not consider Healthmate to be financially viable in the long term. J.A. 719; P.E. 77. Its purpose was merely to "save groups and increase enrollment." *Id.* Indeed, the more people that elected the product, the more money Blue Cross would lose. App., *infra*, 3a-5a. Blue Cross erroneously claims in its response that Healthmate was sold by Blue Cross at a profit. Br. Opp. 5. However, it is clear from the transcript that the evidence was only that Healthmate was sold at a profit to a single group—the employees of the State of Rhode Island government. App., *infra*, 7a-8a. Moreover, even with regard to that single group—the State of Rhode-Island employees—the combined Blue Cross products lost money. App., *infra*, 5a-6a.

[5] Indeed, this Court had no trouble invalidating the defendant's conduct in *United States v. Grinnell*, 384 U.S. 563 (1966), even though it involved the acquisition of other companies, presumably fostering efficiencies to some extent. Similarly, it is unlikely that the result in *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985), or *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951), would have been different if the defendants had suggested some way in which their conduct helped them maximize their profits.

there would be little conduct left condemned by Section 2 except predatory pricing—and such egregious activity as arson directed at a competitor. Nevertheless, other conduct that appears on its face to be consistent with competition on the merits may turn out, on examination under the rule of reason, to be improperly exclusionary.

Raising rivals' costs has been the essence of petitioners' claim since the beginning of this case, respondent's assertions notwithstanding.[6] Petitioners introduced evidence at trial that the goal of the "prudent buyer" policy was to use Blue Cross' purchasing power to force peti-

---

[6] Petitioners' theory of the case was comprehensively set out in its briefs before the court of appeals. Thus, in its opening brief, petitioners stated (Appellants' Br. 18):

> Despite its facial neutrality, the Prudent Buyer policy was designed specifically to harm Ocean State by reducing the number of Ocean State's participating physicians and increasing its costs by forcing it to pay physicians at a premium level in order to ensure that they did not terminate their participation agreements (or, ultimately, to retain non-plan doctors at additional costs) (J.A. 256, 2211a-b).
>
> Blue Cross fully understood the effect its policy would have on Ocean State.

Similarly, in its reply brief in the court of appeals, petitioners stated (Appellants' Reply Br. 6-7):

> Despite the benign face that Blue Cross would paint upon it, the jury had ample evidence before it that the Prudent Buyer policy not only was intended to injure Ocean State by depriving it of its essential competitive resource, a broad panel of participating physicians, and by increasing its costs. In practice, Prudent Buyer was applied in manner far more restrictive to competition than would have been necessary if Blue Cross' stated purpose had been its real one.

It is true, of course, that the scholarly articles regarding the "raising rivals' cost" theory are recent, but no less ardent a disciple of the Chicago School of non-interventionist economics than Judge Easterbrook has apparently recognized the legitimacy of the economic basis of the theory. *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1339-40 (7th Cir. 1986) (no proof of the market power necessary to raise rivals' costs). In any event, the "raising rivals' cost" theory is not a new legal theory, as respondent asserts, but only a characterization helpful in analyzing the potential economic consequences of certain conduct.

tioner Ocean State's physicians to resign, or to at least require Ocean State to pay more for physician services, thereby eliminating price competition in the market for physician services and obviating petitioners' cost advantage.[7] Petitioners also introduced evidence that Blue Cross' conduct had its intended effect: there were mass defections of petitioners' contracting physicians and, in order to compensate for this loss, petitioner Ocean State had to pay more to non-contracting physicians in order to provide necessary medical care to its subscribers.[8]

As a result of Blue Cross' policies, Ocean State's enrollment ceased to grow and it lost business of some employers. Pet. 7; J.A. 65, 163-66, 585-89, 1256-57, 1268, 1426-28; P.E. 739-741, 771-772, 775. At the same time, Blue Cross was able to wipe out a substantial deficit and generate almost $10 million in surplus, largely as a result of profitable price increases which it was able to impose. Pet. 7; J.A. 1110-13.[9]

---

[7] It has been conceded in this case that Blue Cross has monopoly power. *See* Pet. App. 18a, 37a; Br. Opp. 8-9. Indeed, respondent concedes before this Court that its conduct forced petitioners' suppliers to cease doing business with petitioners. *Id.* at 4. Curiously, respondent goes on to assert that there is no evidence regarding its market power in the market for physician services, a claim which respondent did not make before the court of appeals. *Id.* at 15. Yet there can be no doubt that respondent, which had eight times the purchasing power of petitioner Ocean State, had the power to force physicians to resign from Ocean State, and, in fact, exercised that power to the detriment of Ocean State. Pet. 7.

[8] Blue Cross' internal documents estimated these cost advantages to be worth approximately $1.4 million per year to petitioner Ocean State. Pet. 7; J.A. 336-39; P.E. 45. Respondent erroneously asserts that the "prudent buyer" policy did not raise petitioners' costs. Br. Opp. 14. In fact, the evidence clearly showed that Ocean State incurred a debt of approximately $500,000 in increased advertising costs. App., *infra*, 1a-2a. Moreover, Ocean State paid $2 million to replace the services of defecting physicians. App., *infra*, 2a-3a. The fact that Ocean State was able to offset at least some of these additional costs through other savings is irrelevant. J.A. 1443.

[9] Again, Blue Cross wrongly asserts that there was no evidence of higher prices to consumers. Br. Opp. 15. However, the record

Despite respondent's claim and the assumption of the court of appeals, cost savings were not the real goal of Blue Cross' "prudent buyer" policy.[10] The evidence established that Blue Cross made no initial estimates of the savings which its "prudent buyer" policy would achieve, and in fact did not introduce the policy to achieve savings. J.A. 336-37, 350-51. Rather, Blue Cross actually minimized any potential cost savings by changing the implementation date of its "prudent buyer" policy to give physicians adequate time to resign from Ocean State. J.A. 852-55, 1220-22, 1227-31. Moreover, Blue Cross undertook a campaign designed to notify physicians of the date by which resignations had to be submitted to petitioner Ocean State because "Blue Cross didn't have the luxury of waiting another year for Ocean State's physicians to resign." P.E. 45.

Nor can there be any doubt that respondent engaged in this conduct willfully. As the court of appeals recognized, the purpose of Blue Cross' policy was to castrate Ocean State, and Blue Cross officials stated, that "not one guy in the state isn't going to know the implications of signing with Ocean State." Pet. App. 24a. Indeed, the court of appeals conceded that "the jury may reasonably have concluded . . ., that Blue Cross' leadership desired to put Ocean State out of business." *Id.*[11]

---

clearly shows that as a result of policies challenged by petitioners, Blue Cross was able to profitably raise prices. App., *infra*, 6a-7a.

[10] It is, therefore, not surprising that actual savings were de minimis—approximately one-half of one percent of Blue Cross' total private health insurance payments. Pet. 7; J.A. 1232; P.E. 640. Although this reduction in payments to physicians is only a wealth transfer, it might be construed to represent what economists term a "productive efficiency." Lande, *Chicago's False Foundation: Wealth Transfers (Not Just Efficiency) Should Guide Antitrust*, 58 Antitrust L.J. 631, 634 (1989). However, to the extent that the conduct also increased market power so that Blue Cross could increase premiums as it did here, Pet. 7, the conduct also creates an "allocative inefficiency." *Id.* Such inefficiencies must be weighed against any "productive efficiency"—here a minimal benefit even if consumers had realized it.

[11] Unlike other "subjective evidence" which can be consistent with aggressive competition—e.g., "let's get more business"—Blue Cross'

Respondent's argument that it is the victim of price discrimination, which was not made to the court of appeals, nonetheless has been anticipated by amicus AMCRA. In the amicus' words, such a claim by a purchaser with market power is "patently absurd." AMCRA Am. Br. 15. By definition, such a purchaser has the power to demand the best price from its suppliers, if it chooses, and to obtain that price without punishing suppliers for dealing with competitors. Amicus AMCRA astutely observes that what respondent calls "the unusual circumstance of price discrimination *against* a monopoly" should be a red flag indicating that Blue Cross was not really interested in low input prices at all but was instead interested in preventing physicians from marketing themselves through any other outlet. Amicus' account of Blue Cross' monopolistic strategy suggests, at least, that the court of appeals was wrong to resolve the case on the basis of its own assumptions concerning Blue Cross' motives and business objectives.

In any event, whether or not Blue Cross could have negotiated better prices from its physicians is beside the point, as amicus curiae Group Health Association of America, Inc. correctly observes. GHA Am. Br. 14-16. To the extent that physicians were already providing services to Blue Cross at the physicians' marginal costs, then the threatened 20% reduction imposed by Blue Cross would force those physicians to provide their services below cost—unless they resigned from Ocean State. Conversely, if Blue Cross was, in fact, sharing its monopoly profits with physicians, as both petitioners and amicus AMCRA have argued, then reducing fees 20% only to physicians who continued to do business with its rival was hardly the most efficient or least restrictive way to achieve cost savings. Pet. 18-22; AMCRA Am. Br. 13-18.

The simple truth is that Blue Cross didn't know and didn't care whether its policy required physicians to

---

statements in this case clearly evidence an intent to harm Ocean State through the exercise of its market power.

sell below cost. Given its market power, Blue Cross' conduct could have no result other than the one that in fact occurred: a substantial number of petitioner Ocean State's physicians defected, and as a result, petitioner had to increase its payments to physicians.[12]

There can be no question that further guidance is necessary in order to insure that the courts use appropriate antitrust analysis. Indeed, even the trial judge in this case noted:

> What is anti-competitive activity is not a matter that has been clearly defined. There are some significant signposts along the way, but the route is not so clearly marked that departures are unavoidable.

Pet. App. 62a. It is this Court's responsibility to provide the kind of clearly marked signposts that will prevent monopolists from maintaining their monopoly power through non-price predation in ways that create harm to consumers through higher prices. Otherwise, monopolists will be free to exert their economic power free of any fear of challenge simply by establishing a possible "efficiency" or "business" justification. Indeed, there is reason to believe this is already happening in the health insurance industry.[13] GHAA Am. Br. 4-5; Kaiser Am. Br. 4-5; USHC Am. Br. 13-14.

---

[12] This fact demonstrates the fallacy of the "below incremental cost" test imposed by the court of appeals. Pet. App. 19a-20a. Whether or not, by reducing fees to Ocean State physicians by 20%, Blue Cross was forcing those physicians to sell below their costs, the economic effect of the policy would be to drive many physicians out of Ocean State given the disparity in purchasing power between Ocean State and Blue Cross. In addition, the court of appeals' test imposes an impossible burden on a plaintiff—i.e., establishing the cost of production of each of the 1200 Ocean State physicians.

[13] Respondents also argue that the court of appeals' opinion can be affirmed on separate grounds—i.e., the jury did not allocate the damages to the antitrust claim. Br. Opp. 18-19. The simple answer to this claim is that the court of appeals' decision does not rest on that rationale. Pet. App. 8a-11a.

The McCarran Act Should Not Bar an Examination of Respondent's Conduct

Respondent states that the McCarran Act "would have been unnecessary if it were merely duplicative of the generally applicable state action doctrine." Br. Opp. 17. But when the McCarran exemption was passed and even when it was first contrued to require only the existence of a general regulatory scheme in *FTC v. National Casualty Co.*, 357 U.S. 560, 564-65 (1958), the state action doctrine had not taken its current form. Indeed, the requirement of active state supervision was finally clarified only in the 1980 decision in *California Retail Liquor Dealers' Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 104-06 (1980). Surely the implied immunity for actively regulated insurer conduct was not so clear in 1945 that the McCarran exemption must be deemed, simply because it is explicit, to exempt conduct that the implied exemption does not cover. After all, the "state action" immunity that was subsequently found implicit in the Sherman Act is based on the same concerns regarding federalism that appeared when state regulation of the business of insurance was threatened by *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 562 (1944).[14]

---

[14] In immunizing respondent's "adverse selection" factors and Healthmate product, the court of appeals displayed a remarkable tolerance for conduct designed, not to enhance efficiencies, but to destroy a competitor through the willful exercise of market power. Thus, the Court failed to analyze the consequences of the "adverse selection" factors—which permitted respondent to manipulate actuarial calculations in order to use its market power to discourage employers from doing business with petitioner Ocean State even though respondent initiated these practices without the requisite approval of the state. Moreover, the Court held that the coercion exception was not raised in a timely manner by petitioners. Yet the district court did not hold that the McCarran immunity was applicable. Pet. App. 56a. Thus, it was respondent's responsibility to raise the issue on appeal. Petitioners were, therefore, timely in arguing in their reply brief that the "coercion" exception applied. Similarly, the court of appeals held that McCarran immunized the marketing of the Healthmate product—characterized by Blue Cross itself as losing money in direct proportion to its use (App., *infra*, 5a)—even

This Court Has Authority to Review the Court of Appeals Action Regarding the State Law Claims

Finally, respondent argues that this Court cannot review the court of appeals' rejection of the jury's damages award rendered on the tortious interference claim because that claim is grounded in state law. Br. Op. 19-20. As respondent concedes, after being appropriately charged regarding the elements of the state law claim, the jury found substantial damages for petitioner Ocean State, and its class of physicians. The court of appeals nevertheless disregarded that verdict, holding—without benefit of any citations to Rhode Island case law—that the conduct at issue could not be violative of state law unless it was also "exclusionary" under federal antitrust law. Respondent now apparently claims that it is appropriate for the federal court of appeals to arrogate to itself a determination regarding state tort law but that it would violate accepted principles of federalism for this Court to review the appropriateness of the court of appeals' determination.

CONCLUSION

For the foregoing reasons, and for the reasons contained in the petition for a writ of certiorari, petitioners submit that the Court should grant certiorari to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

WILLIAM G. KOPIT *
ROBERT W. MCCANN
EPSTEIN BECKER & GREEN, P.C.
1227 25th Street, N.W.
7th Floor
Washington, D.C. 20037
(202) 861-0900
Counsel for Petitioners

* Counsel of Record

Of Counsel
CLARK C. HAVIGHURST
Duke University Law School
Durham, N.C. 27706

THOMAS E. LYNCH
LYNCH AND GREENFIELD
203 South Main Street
Providence, R.I. 02903

---

though respondents never claimed McCarran immunity with respect to that product. Pet. 25 n.21.

APPENDIX

APPENDIX

I. Excerpts from the testimony of Robert Suellentrop (J.A. at 154-55):

THE COURT: We are talking about the effect of the Prudent Buyer Plan, if any, on Ocean State.

THE WITNESS: Yes, there was a direct effect.

THE COURT: Now you tell us you had a mass disaffiliation of physicians.

THE WITNESS: Yes, Sir.

THE COURT: Now what else, if anything, happened?

THE WITNESS: The other effect is that because of the disaffiliation of physicians, we had to do something to make sure that the public understood that it was not the end of Ocean State, that we weren't going to go out of business, and so we had to have a significant advertising and public relations campaign.

THE COURT: You had P.R. campaign, right?

THE WITNESS: Yes, Sir, a significant one.

Q How much did it cost?

A In total we spent about two hundred thousand dollars in that fourth quarter when we would not—

THE COURT: That was just on this business of this mass disaffiliation or was it on something else?

THE WITNESS: It was the advertising and public relations campaign that was developed to specifically address that issue and was developed with the assistance of Duffy & Shanley Advertising Firm.

Q Would this campaign have been undertaken if not for the imposition of the Prudent Buyer?

A No, sir.

J.A. at 168-69:

Q And as to 1987, what does that show?

A Six hundred thirty-five thousand dollars is being budgeted and will be spent in 1987 on advertising expenses.

Q To what extent, if any, do you relate that to Prudent Buyer?

A I relate it to about three hundred and thirty-five thousand dollars worth. The industry average indicates that IPA models of our size will be spending over two hundred thousand dollars this year on advertising expenses. I would say that three hundred thousand dollars is a more realistic target but we have had to spend twice that much because of the activities that have taken place.

J.A. at 181-82:

Q What experience in 1987 did you look at?

A We looked at what we actually have paid per service for those four specialties of orthopedics, anesthesiology, surgery—I forgot one; anesthesiology, orthopedics, surgery and radiology, and compared that with what we expected in the budget to pay for those services.

Q And what is the difference?

MR. SNOW: Objection.

THE COURT: Just a moment. I will allow the question.

What is the difference between the actual and the budget figure?

THE WITNESS: Approximately two million dollars.

Q Did Ocean State experience in 1986 any additional costs as to contracting physicians?

A The year again?

Q 1986.

A I need you to repeat the question.

Q Was there any change within 1986 or any addition in 1986 to budgeted costs for contracting physicians?

A We had to make some adjustments in November of 1987 but I don't have a specific dollar—

Q You said 1987.

A November, 1986 but I do not have a specific amount.

Q Did you have to make any changes as to 1987 in cost for contracting physicians?

A Yes, sir.

Q And what changes, if any, did you make?
A We had to enter into special contractual arrangements to either pay bill charges or match another fee schedule for those four specialties in particular.
Q And what was the total cost of that change?
A Approximately two million dollars.

J.A. at 255-56:

Q Now obstetricians who did disaffiliate or indicate an intention to disaffiliate from Ocean State, did you bring back or retain any of them?
A Of those physicians who in the fall of 1986, of those physicians who indicated that they were intending to disaffiliate, yes, we did bring some back and they withdrew their intention to disaffiliate—
Q Was anything—
A Others did not.
Q Excuse me. I didn't mean to interrupt you. Did you finish your answer?
A Some other physicians, obstetricians, did not withdraw their intention to disaffiliate and did in fact do so.
Q As to the ones who did withdraw their intentions to disaffiliate and stayed or came back, were any changes made as to their renumeration [*sic*]?
A To those physicians who decided to stay with us?
Q Yes.
A We did adjust the fee profile for about sixteen different procedures, normal vaginal deliveries being one, and about thirteen or fourteen GYN procedures. There was a payment issue that was of real concern to them and we adjusted to that.

II. Excerpts from the testimony of Raymond Baedeker (J.A. at 1091-94):

Q The HealthMate program was only going to be offered selectively where Ocean State was a threat to the Blue Cross standard plan, isn't that fair?
A That's correct.

Q And before you put the HealthMate product on the market with the State of Rhode Island on July 1, '86, did you estimate the savings and losses that you would have from HealthMate prior to July 1 of '86?

A No, we did not.

Q And do you usually make such estimates before you introduce a new product into the market?

THE COURT: What do you mean by "savings"?

Q I'm sorry, I meant did you estimate what you thought the product would make or lose for you before you introduced it into the market?

A We did not.

Q Do you usually make such estimates of profits or losses of a new product before you introduce them into the market?

A Not necessarily.

Q I said do you usually.

A Very often we do.

Q But you didn't in this case?

A We did not.

Q Can you tell us why you didn't make such estimates with regard to HealthMate?

A We didn't feel that that was necessary. This was a product that we felt was necessary to put on the market.

Q It was necessary to put it on the market?

A That's correct.

Q Can you take a look at Page 2 of this integrated rating policy that's part of Attachment 37. We put up a transparency there. At the bottom of this page after it says "financial analysis," there's some estimates of the impact of certain numbers of transfers to the HealthMate product, is there not?

A Yes.

Q And if you look at the column on your left, it says "actual transfers to plus 15%" and as I read across if you got 15% of the enrollment in the plus product, you would break even, is that true?

A That's true.

Q And that's whether or not the standard rates were set the same as the plus rates or set at 5% below, correct?

A That's correct.

Q And you had that option as to where to set the two rates?

A Yes.

Q And that was done on the basis of what marketing thought made sense from a marketing standpoint?

A That's correct.

Q But under either case if you got 15% of the population of plus, you'd break even. I take it, it's not shown there, but if you got 5% or 10% of the population, I take it you'd make money?

A That is also correct.

Q But if you got 20% you started to lose money under those estimated, don't you?

A That's correct.

Q And the more people you get in the program, the more money you lose, right?

A Yes.

J.A. at 1096:

Q Do you know whether in fact for that year, that is, the year beginning July 1, of '86 Blue Cross lost money on the contract with the state, total contract with the state?

A When you define the total contract of the state, are you including HealthMate?

Q I'm including both together, basic Blue and HealthMate, the contract was for both, wasn't it?

A Yes.

THE COURT: Either.

THE WITNESS: The answer is yes.

Q You did?

A In total.

Q Yes, and was that amount about $2,500,000?

A I don't recall the amount.

Q Do you know whether that amount was in fact substantially greater than the loss the year before when you had not had HealthMate?

A I don't recall those amounts.

Q You don't know that?

A I do not.

J.A. at 1110-12:

Q So that for the year '85 and the first two quarters of '86, we're talking about a loss of what, 12,000,000, and another thirteen or so million for the first two quarters?

A Yes.

Q Take a look at Plaintiff's Exhibit 369. I'm sorry, again I missed one, take a look at 112 first. This is the quarterly report for the last quarter of '86, do you see that again on the second page?

A I do.

Q And that shows again in the last quarter of '86 of 7,670,434, you see that?

A I do.

Q And that's for experience rated groups?

A That's correct.

Q And now take a look lastly at 369, you see that second page?

A I do.

Q And that one is for the first quarter of '87, isn't it?

A That is the first quarter of '87.

Q And that shows a gain in experience rated groups for 2,206,870, correct?

A That is correct.

Q So the picture is that from losing a lot of money in experience rated groups in '85 and the first two quarters in '86, by the last quarter of '86 and the first quarter of '87 you were making a lot of money on experience rated groups, you were at least making money?

A We were making money.

Q And that is a significant turnaround, isn't it?

A It is a turnaround.

Q And isn't the reason for that turnaround that basically that you started increasing your rates?

A That is a part of the reason.

Q Is it a significant part of the reason?

A I'm not sure about the reference to significant. It is an important part of the reason.

J.A. at 1124-26:

Q What group was HealthMate offered to first?

A The State of Rhode Island employee group.

Q You testified on your direct examination that no estimate was made of what HealthMate would make or lose before it was marketed, could you tell me why that was done for HealthMate specifically?

A That was not done because we didn't really feel the need to do it. We knew it was a product that had to be, in our view, had to be placed on the market. So we went ahead and developed the product and rated it.

Q What was happening with Blue Cross' HMO Rhode Island at that time?

A At that time we were waiting for approval to operate HMO Rhode Island.

Q Had that request for approval been filed for some time before the Department of Business Regulations?

A Yes.

Q Have you recently received any preliminary results with respect to how HealthMate did in the State of Rhode Island over its first 12-month period?

A Yes.

Q And what are they?

A Unfortunately I don't recall the amount of money, however, it was a gain. A gain in the sense of income was in excess of claims expense.

Q And is that gain used to offset losses in other areas?

A Yes.

Q Have you, Blue Cross, been marketing HealthMate to other employee groups?

A Yes.

Q What kind of groups?

A Groups in Class IER.

Q Have you received any results yet from these groups as to whether HealthMate operated at a gain or a loss?

A I have not.